

Vaccines for Children VFC Program Enrollment



Department of
Public Health
CITY OF PHILADELPHIA
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VFC PROGRAM PROVIDER AGREEMENT

FACILITY			
Facility Name			VFC PIN
Facility Address			
City	County	State	Zip Code
Phone Number		Fax Number	
Shipping Address (if different than facility address)			
City	County	State	Zip Code

MEDICAL DIRECTOR OR EQUIVALENT		
<p>Instructions: The official VFC registered healthcare provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under state law who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlines in the provider enrollment agreement. The individual listed here must sign the provider agreement.</p>		
Last Name, First, MI	Title	Speciality
License #	Medicaid or NPI #	Employer ID #

VFC VACCINE COORDINATOR	
Primary Vaccine Coordinator Name	
Phone Number	Email
Completed "You Call the Shots" module? <input type="checkbox"/> Yes <input type="checkbox"/> No	CE Code
Back-up Vaccine Coordinator Name	
Phone Number	Email
Completed "You Call the Shots" module? <input type="checkbox"/> Yes <input type="checkbox"/> No	CE Code

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OFFICE HOURS (Indicate lunch hours only if closed during lunch and unable to accept packages)				
Monday	Tuesday	Wednesday	Thursday	Friday
Lunch	Lunch	Lunch	Lunch	Lunch

Type of Facility (choose one)

- Public Health Department
 Private Hospital
 Private Practice - Individual/Group
 Other Private Practice
 Other Public Clinic
 Federally Qualified Health Center (FQHC)

Type of Practice (choose one)

- Pediatric
 Family/General Practice
 Obstetrics/Gynecology
 Family Planning Clinic
 Inpatient: _____
 Speciality: _____

PATIENT DATA				
Use patient data for exact numbers on patient totals, and estimate the number of children in the age ranges who will receive immunizations at your practice or for a 12-month period:	Ages (Do not count a child in more than one category)			TOTAL
	< 1 Year	1-6 Years	7-18 Years	
Total VFC Population				
a. Enrolled in Medicaid				
b. Uninsured				
c. American Indian or Alaskan Native				
d. Underinsured (FQHCs only)				
Non-VFC Eligible				
All Children				

Type of Data Used for Patient Totals Above (choose one)

- Medicaid Capitation list
 Provider Encounter Data
 Medicaid Claims Data
 Doses Administered
 Other: _____

VACCINE STORAGE UNITS

Indicate your **REFRIGERATOR** storage unit types below:

Type:
 Small/under counter*
 Combination
 Stand alone refrigerator
 Commercial/pharmacy grade
 Number of Units: _____ Storage Capacity in Cubic Feet: _____

Type:
 Small/under counter*
 Combination
 Stand alone refrigerator
 Commercial/pharmacy grade
 Number of Units: _____ Storage Capacity in Cubic Feet: _____

**Dormitory style units are not acceptable for vaccine storage.*

Primary **THERMOMETER** Type:

Digital with Glycol-encased Probe
 Data-logger
 None
 Other: _____ Date of Last Calibration: _____

Back-up **THERMOMETER** Type:

Digital with Glycol-encased Probe
 Data-logger
 None
 Other: _____ Date of Last Calibration: _____

Indicate your **FREEZER** storage unit types below:

Type:
 Small/under counter*
 Combination
 Stand alone freezer
 Commercial/pharmacy grade
 Number of Units: _____ Storage Capacity in Cubic Feet: _____

Type:
 Small/under counter*
 Combination
 Stand alone freezer
 Commercial/pharmacy grade
 Number of Units: _____ Storage Capacity in Cubic Feet: _____

Primary **THERMOMETER** Type:

Digital with Glycol-encased Probe
 Data-logger
 None
 Other: _____ Date of Last Calibration: _____

Back-up **THERMOMETER** Type:

Digital with Glycol-encased Probe
 Data-logger
 None
 Other: _____ Date of Last Calibration: _____

The information supplied on this form is complete and accurate to the best of my knowledge. I understand that this information will be used to determine the amount of vaccine needed by my practice and agree to submit an updated profile if there are changes in: the number of eligible children seen, the status of the practice, vaccine contact or shipping information.

Signature	Date	VFC PIN
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VACCINES OFFERED

- All ACIP Recommended Vaccines for children 0 through 18 years of age.
- Offers Select Vaccines (This option is only available for facilities designated as Specialty Providers by the VFC Program)

A “Specialty Provider” is defined as a provider that only serves (1) a defined population due to the practice specialty (e.g. OB/GYN; STD clinic; family planning) or (2) a specific age group within the general population of children ages 0-18. Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC Program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Specialty Provider:

- DTaP
- Hepatitis A
- Hepatitis B
- HIB
- HPV
- Influenza
- Meningococcal Conjugate
- Meningococcal B
- MMR
- Pneumococcal Conjugate
- Pneumococcal Polysaccharide
- Polio
- Rotavirus
- TD
- Tdap
- Varicella
- Other, specify: _____

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VFC PIN

Instructions: List below all licensed healthcare providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.

PROVIDERS PRACTICING AT THIS FACILITY

Provider Name	Title	License No.	Medicaid or NPI No.	EIN (Optional)

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PROVIDER AGREEMENT	
To receive publicly-funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the healthcare facility of which I am the medical director or equivalent.	
1	I will annually submit a provider profile representing populations served by my practice/facility. I will submit more frequently if 1) the number of children served changes or 2) the status of the facility changes during the calendar year.
2	<p>I will screen patients and document eligibility status at each immunization encounter for VFC eligibility (i.e. federally or state vaccine-eligible) and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following categories:</p> <p>A. Federally Vaccine-eligible Children (VFC eligible)</p> <ol style="list-style-type: none"> 1. Are a Native American or Alaska Native 2. Are enrolled in Medicaid 3. Have no health insurance 4. Are underinsured: A child who has health insurance, but the coverage does not include vaccines; a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC), or under an approved deputization agreement. <p>B. State Vaccine-eligible Children</p> <ol style="list-style-type: none"> 1. In addition, to the extent that my state designates additional categories of children as “state vaccine-eligible,” I will screen for such eligibility as listed in the addendum to this agreement and will administer state-funded doses (including 317 funded doses) to such children. <p>Children aged 0 through 18 years who do not meet one or more of the eligibility federal vaccine categories (VFC eligible), are not eligible to receive VFC-purchased vaccine.</p>
3	<p>For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless:</p> <ol style="list-style-type: none"> 1. In the provider’s medical judgement, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the child. 2. The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4	I will maintain all records related to the VFC program for a minimum of three years and upon request make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5	I will immunize eligible children with publicly supplied vaccine at no charge to the patient for the vaccine.
6	<p>VFC Vaccine Eligible Children</p> <p>I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of \$23.14 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.</p> <p>Non-VFC Vaccine Eligible Children</p> <p>I will not charge a vaccine administration fee to non-Medicaid state vaccine eligible children that exceeds the administration fee cap of \$23.14 per vaccine dose.</p>
7	I will not deny administration of a publicly purchased vaccine to an established patient because the child’s parent/guardian/individual of record is unable to pay the administration fee.

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PROVIDER AGREEMENT	
8	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
9	I will comply with the requirements for vaccine management including: <ol style="list-style-type: none"> 1. Ordering vaccine and maintaining appropriate vaccine inventories. 2. Not storing vaccine in dormitory-style units at any time. 3. Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Philadelphia Department of Public Health's Immunization Program storage and handling requirements. 4. Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration.
10	I agree to operate within the VFC program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and for the purposes of the VFC Program: Fraud: is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Abuse: provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary cost to the Medicaid program.
11	I will participate in VFC program compliance site visits including unannounced visits, and other educational opportunities associated with VFC program requirements.
12	I agree to replace vaccine purchased with federal funds (VFC, 317) that are deemed non-viable due to provider negligence on a dose-for-dose basis.
13	I understand that immunization administration is a reportable event as per the Philadelphia Health Code § 6-210. I will make information on immunizations administered to all patients available to the Division of Disease Control's KIDS Plus IIS.
14	I understand this facility or Philadelphia Department of Public Health's Immunization Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by Philadelphia Department of Public Health's Immunization Program.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vaccines for Children enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.

Medical Director or Equivalent Name (print)	VFC PIN
Signature	Date

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RECENT STORAGE & HANDLING REQUIREMENTS

The VFC Program recently updated Storage & Handling policies.

- The VFC Program now requires all VFC vaccine storage units to be monitored by a certified, calibrated digital data logger.
- The VFC Program now requires all VFC providers to have a back-up thermometer.
- The VFC Program no longer allows VFC vaccine to be stored in the freezer unit of a household combination refrigerator/freezer. VFC vaccine previously stored in a combination refrigerator/freezer unit must be stored in stand-alone freezer units.

These policies effective now.

By signing this form, I verify that I have read the STORAGE & HANDLING UPDATE, I understand the VFC storage & handling policies listed above, and acknowledge that I am responsible for compliance with these requirements.

Medical Director or Equivalent Name (print)	VFC PIN
Signature	Date

Fax the complete VFC enrollment packet to 215-238-6948